East Syracuse Minoa Central Schools

East Syracuse Minoa Central High School
6400 Fremont Road
East Syracuse, NY 13057
Questions? Call (315) 434-3011 or email register@esmschools.org

Medical Background (to be completed for all students by the parent/guardian)

Student's Name ____________________________________ **Grade** ________ **Birth date** ___________

☐ My child will have a physical with his/her private Health Care Provider.

The following documents are to be completed by a Health Care Provider

1. Section 2 of the Dental Health Certificate (Page 11)
2. Health Appraisal Form (Page 8)

☐ I am requesting a physical examination with the school doctor.

Health Care Provider's Name ____________________________________ Phone # __________________________

Number of children in the family? _____________ Position of this child in the family? ________________

Has your child had any of the following conditions? Please check and explain all that apply.

	Asthma		Ear Conditions/Defect		Scarlet Fever
	ADD/ ADHD		Eye Conditions/Defect		Seizure Disorder/Epilepsy
	Anemia		Heart Disease		Whopping Cough
	Bleeding Tendency		Kidney Disease		Operations
	Bone / Joint Disease		Nervous Disorder		
	Diabetes		Pneumonia		Serious Injuries
	Allergies: (drug, food, environmental)				

Please explain the checked areas here.

Please list any other serious problems this child has had from birth to present:

Does your child wear: (Please circle all that apply)
Glasses   Contact Lenses   Hearing Aid(s)   Orthodontic (Teeth) Braces
Orthopedic Brace: (Please circle) Right, Left or Both; Wrist, Knee, Ankle, Other body part –

Medication Information

Is this child currently taking medication prescribed by a physician? **YES** / **NO.**
If **YES**, please list below.

Name of Medication	Dose and Frequency	Reason Taking Medication
1.		
2.		
3.		
4.		

Please note: If any medication is to be dispensed during school hours, a Form #2525a, Authorization for Dispensing Medication, must be completed by the student's Health Care Provider *and* parent or guardian and brought to the school nurse with the medication. Form #2525a and additional information can be obtained from the school nurse.

Emergency Information

In the event a parent/guardian cannot be reached, I give my permission for emergency medical treatment to be administered to my son / daughter. Also, I give permission for this information to be given to emergency medical personnel.

_______________________________________ ____________________________
Signature of Parent / Guardian   Date